Request for Waiver of Group Medical Coverage

This form is to be used for declining Medical coverage only. If you wish to decline other coverage(s), you will also need to complete the standard waiver or enrollment form.

Firm Name _____ **Account Number** _____

Employee _____ **ID Number** _____

I hereby certify that I have been given an opportunity to apply for group coverage issued by Coventry Health Care, Inc. I understand the coverage available and decline medical coverage. *Check proper boxes to decline coverage.*

I decline Medical Coverage

- ❑ for myself
- ❑ for my spouse
- ❑ for my children
- ❑ for my spouse and children

Name of Spouse _____

Name(s) of Children _____

_____

_____

_____

Reason for Waiving Coverage

- ❑ Individual Plan
- ❑ Government Plan
- ❑ Spouse's Group Plan
- ❑ Other _____

I understand if I decline medical coverage under this plan my dependent(s) are not eligible for any coverage for which I am not insured.

Employees who decline medical coverage for themselves and/or their dependents during the initial enrollment period and then, more than 31 days later, request coverage will be considered to be late enrollees. Late enrollees may be subject to an exclusion from coverage for the maximum months allowed per State regulations. However, an eligible employee will not be considered a late enrollee for employee and/or dependent coverage (and coverage will not be deferred) if (a) late enrollment is made under one of the circumstances described below; and (b) required information or proof is furnished.

Late Enrollees Expectations

An eligible employee will not be considered a late enrollee for employee and/or dependent coverage if (a) late enrollment is made under one of the circumstances described below; and (b) any required information or proof is furnished.

1. **Termination of Other Health Coverage**: Request for enrollment is made within 31 days after termination of other health coverage, and (a) the employee certifies that enrollment under this plan was initially declined solely due to the other coverage; and (b) termination of the other group coverage is due to involuntary termination of employment or eligibility, the involuntary termination of the previous coverage, death of a spouse or divorce.
2. **Court Order**: Request for enrollment is made within 31 days after issuance of court order that coverage be provided for the spouse and/or minor child(ren) of a covered employee.
3. **Election of Different Plan During Open Enrollment Period**: The employer offers multiple health plans, and request for enrollment under this plan is made during the open enrollment period established for plan election.

I hereby acknowledge the above warning regarding the consequences of declining medical coverage at my initial enrollment. I declare that the information given on this waiver is correctly recorded, complete and true.

Signature _____ Date Signed _____